❑ Initiate Waiver services
❑ Service Modification
  □ Add a service
  □ Increasing hours of service
  □ Decreasing hours of service
❑ Change in SF (requires 2 ISARs)
❑ End CD service

MR/ID Waiver
Consumer-Directed Personal Assistance
Individual Service Authorization Request

CSB _____

CSB provider #

_____

Last First MI	Medicaid No:
Name:	
Address: Street/Apt. City, State Zip Code	
Phone No.	
Services Facilitator: _____ SF E-mail Address: _____	
SF agency, if applicable_____ Provider No:	

Will the individual be directing his or her own services? ☐Yes ☐No

If NO, name and relationship of responsible family member/caregiver:_____

SERVICE REQUESTED	WEEKLY/BI-WEEKLY HOURS			ODS USE ONLY
CD PA services start date may not precede: SF Start Date:_____ SF End Date:_____ S5126--CD PA Start Date: _____ S5126--CD PA End Date: _____ Total # of persons with disabilities in the residence_____	_____ Hours / week	x 2 =	_____ Bi-weekly total	
Enter periodic support hours per month if needed **(Do not include these hours in weekly schedule below)** →	_____ Hours/month			

Reason for this request:_____

_____

_____

Check the allowable activities included in the individual's PFS. Indicate the *total* number of hours per day of CD PA.

Support with	**Sun**	**Mon**	**Tue**	**Wed**	**Thur**	**Fri**	**Sat**
☐ activities of daily living ***(Must be included to receive this service)***							
☐ monitoring health status & physical condition							
☐ self-medication and/or other medical needs							
☐ meal preparation and eating							
☐ housekeeping activities							
☐ participating in social/recreational/community activities							
☐ appointments or meetings							
☐ bowel/bladder programs, range of motion exercises, routine wound care (per MD's orders and RN oversight)							
☐ assuring the safety of the individual							
☐ activities in the workplace or post-secondary school (does not duplicate ADA or SE services)							
Training for assistant							
☐ as requested by the individual or caregiver that relates to services described in the PFS							

Comments:

_____ _____

Signature of Services Facilitator — Date

I agree that the above plan for supports is appropriate to the identified needs of this individual. This PFS has been approved by the individual and included in the ISP maintained in the Support Coordinator's/Case Manager's record.

_____ _____ _____

CSB Rep/Supp. Coord./Case Manager (print) — Phone No. — Fax No.

_____ _____

Signature — Date